

Admission	Admission Date	Admission Type	Discharge Date
	9/14/2007 (Initial)	EMERGENCY	9/20/2007

Patient

Demographics

Name	Patient ID	SSN	Sex	Birthdate
VENTRELLA, BERENICE	011293677	xxx-xx-7386	Female	3/18/1919 (88 yrs)
Address	Phone	EMail	Employer	
2311 DORINA DRNORTHFIELD, IL 60093	847-441-7747(H)		NONE	
Reg Status	PCP	Date Last Verified	Next Review Date	
VERIFIED	SHAPIRO, SUSAN D. 847-729-8833	5/13/2005		

**Allergies:
Problem List**

(No Known Allergies) Date Reviewed: 09/20/2007	Problem	Noted	Resolved
	ACUTE MYOCARDIAL INFARCT (aka MYOCARDIAL) [410]	4/17/2003 by SHAPIRO, SUSAN D.	5/15/2003 by SHAPIRO, SUSAN D.
	CONGESTIVE HEART FAILURE [428.0]	5/13/2005 by SHAPIRO, SUSAN D.	No
	Class: Active		
	DIABETES MELLITUS [250]	4/17/2003 by SHAPIRO, SUSAN D.	No
	Class: Active		
	BACKACHE NOS (aka BACK PAIN) [724.5]	5/15/2003 by SHAPIRO, SUSAN D.	5/17/2005 by SHAPIRO, SUSAN D.
	Class: Acute		
	BENIGN HYPERTENSION [401.1]	9/30/2003 by WISDOM, PAULINE E	No
	ACUTE RESPIRATORY FAILURE [518.81]	5/13/2005 by INTERFACE, REG/ ADT INCOMING	9/17/2007 by SHAPIRO, SUSAN D.
	Class: Active		
	CHR ISCHEMIC HRT DIS NOS [414.9]	5/17/2005 by SHAPIRO, SUSAN D.	No
	MITRAL/AORTIC STENOSIS [396.0]	5/17/2005 by SHAPIRO, SUSAN D.	No
	ED DIAGNOSIS [999998]	9/14/2007 by INTERFACE, REG/ ADT INCOMING	9/17/2007 by SHAPIRO, SUSAN D.
	Comment: altered mental status		
	Urinary Tract Infection, Site not Specified [599.0]	9/14/2007 by INTERFACE, REG/ ADT INCOMING	No
	Hallucinations [780.1]	9/17/2007 by SHAPIRO, SUSAN D.	No
	Urinary Retention [788.20B]	9/17/2007 by SHAPIRO, SUSAN D.	No
	Class: Acute		

Chief Complaint

MENTAL STATUS
CHANGES

**Reason for
Admission**

ED DIAGNOSIS [999998] altered mental status
 Urinary Tract Infection, Site not Specified [599.0]

END OF REPORT

Ex.B

Consult Notes

All notes

Author

Sadiya Khan

Service

(none)

Author Type

Medical

Filed

09/15/2007 1109

Student

Note Status

Revised

Related Notes

Cosigned by : PATEL, SMITA at 09/15/2007 1229

Addendum by : PATEL, SMITA at 09/15/2007 1229

M3 Student Note (Neurology Consult)

Reason for consult: Mental status changes

Sources: patient and previous records

HPI:

This is a 88 year old female with PMH of DM, CHF, CAD, and ishcmic cardiomyopathy who presented to the ER for evaluation of acute mental status changes. Patient states that for the past five days she has been unable to sleep because of all the "commotion" with the angels, prior business partners, and dancing occuring at home. Patient denies currently seeing any angels, but continues to question the presence of other people in the room and began talking to someone else during the interview. When asked who she was talking to, patient stated, "the 10 other people in the room". However, patient has history of cataracts and vision is grossly impaired. Patient denies any auditory hallucinations. On further questioning patient states that she has been seeing these angels for almost a year.

Patient is not able to get out of bed and according to the chart has not walked in over 6 months. Patient states that she had a fall 8 months, PT was attempted but not sucessfully completed because she did not like them. Patient states that she has a walker at home, but stays completely in bed, using a bedpan to relieve herself. Patient states that her diet is mostly liquid including oatmeal and juices.

Patient denies any active complaints and states that she was simply brought in to the ER for a "check-up" and would like to go home. Patient lives at home with her husband and son who care for her. Patient is actively involved in business deals concerning real estate exchanges and her business partner states that he has noticed any change in intelligence, concentration, or business sense.

PMH:

DM, CAD, Ischemic cardiomyopathy, CHF
2 prior MIs

PSH:

No past surgical history on file.

Allergies:

No Known Allergies.

Medications:

Lasix 40 mg QD

Potassium 10 mEq BID

Note StatusPage 3 of 16 Related Notes

Coreg 25 mg BID
 Humilin 70/30 7 U before breakfast and 3 U before dinner
 Imdur 30 mg daily
 Quinipril 20 mg BID
 Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN), 325 mg,
 Ciprofloxacin 400 mg (CIPRO), 400 mg, Intravenous, NOW THEN Q24HR,
 Heparin SOLN 5,000 Units (HEPARIN), 5000 Units, Subcutaneous, Q8HR, ALI,
 AMAN

Social History:

Patient lives with husband and son and is actively still involved in running her own business with partner dealing with real estate.

Physical Exam:

BP:
 133/59

Pulse:
 69

Temp:
 98.1 F (36.7 C)

Resp:
 16

Height:
 4' 8" (1.422 m)

Weight:
 99 lbs 8.0 oz (45.133 kg)

General: NAD

CV: rr, no m/r/g, no peripheral edema, no carotid bruit

Lung: CTAB

Neuro:

Mental Status: alert and oriented to person, place, and time.

Tangential thought process with persistent visual hallucinations of people and angels in room. Recall 2/3 immediately and 2/3 at 5 minutes.

MMSE showed deficits in concentration and memory and was unable to complete because patient is unable to see bilaterally due to cataracts.

CN II, III, IV, VI: patient unable to follow light, finger, but can point to where I am sitting; pupils equal and reactive to light.

CN V: mastication and sensation intact

CN VIII: hearing grossly intact to finger rub bilaterally

CN IX, X: palate strong and midline

CN XI: trapezius/scm 5/5

CN XII: tongue midline

Motor:

Tone normal and power diminished in LE 4/5 with atrophy of lower leg muscles; UE 5/5. No pronator drift, tremor, or rigidity. Arthritic changes noted in feet.

Sensory: decreased vibration and position sense in LE; intact sensation to pinprick, temperature and light touch. Babinski flexor responses bilaterally.

Reflexes:

2+ throughout

Coordination/Gait:

FTN performed with difficulty. Unable to get out of bed.

Impression:

1. Long term visual hallucinations, possibly exacerbated by recent UTI not consistent with dementia.

Plan:

1. Continue present management
2. Consider benzodiazepine for sleep if insomnia persists.

<u>Author</u>	<u>Service</u>	<u>Author Type</u>	<u>Filed</u>
Smita Patel	(none)	Physician	09/15/2007 1229
<u>Related Notes</u>			
Related note : KHAN, SADIYA at 09/15/2007 1109			
Original Note : KHAN, SADIYA at 09/15/2007 1109			

M3 Student Note (Neurology Consult)

Reason for consult: Mental status changes

Sources: patient and previous records

Requesting physician: Dr. Unger

HPI:

This is a 88 year old female with PMH of DM, CHF, CAD, and ischemic cardiomyopathy who presented to the ER for evaluation of acute mental status changes. Patient states that for the past five days she has been unable to sleep because of all the "commotion" with the angels, prior business partners, and dancing occurring at home. Patient denies currently seeing any angels, but continues to question the presence of other people in the room and began talking to someone else during the interview. When asked who she was talking to, patient stated, "the 10 other people in the room". However, patient has history of cataracts and vision is grossly impaired. Patient denies any auditory hallucinations. On further questioning patient states that she has been seeing these angels for almost a year.

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Related Notes

Page 5 of 16

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133/59

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98.1 F (36.7 C)

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Related Notes

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Sadiya Khan

I performed a history and physical examination of Berenice Ventrella and discussed her management with the medical student. I reviewed the student's note and agree with the documented findings and plan of care except where indicated

Related Notes

HPI:

requesting Physician: Dr. Unger

Reason for referral: MS changes with hallucinations

Source: patient and her husband over the phone

This is a an 88 year old lady with multiple medical problems who presents with 1 year to 6 months of hallucinations while at home. When talking to her husband if anything else is going on, he states, "no. just wanted to get her checked out." According to him, she is with it some days and not so clear other days. She has been sitting in her bed and usually gives orders to everyone. In the house, live her husband and son, Nick. Nick seems to be in charge of her medical care and gives her medications, etc. Angelo states he is in charge of the cleaning up. She has not been getting up to use the bathroom. Angelo gives her a sponge bath every now and then.

Nick takes care of the finances but her business partner John who was here to visit her this AM, states she has been pretty with it so far.

Angelo agrees that she seems to know her business stocks etc.

When I first walked in the room, Berenice was talking to herself or to angels. She waited for a response and seemed to answer back. She denies hearing her hallucinations but does admit to seeing her parents, other people. She never tries to chase them because she can not walk. She does not appear to be harmed by them. She does state that her sleep was poor because they keep her awake.

She has only one complaint and that is some pain in the right lower leg with palpation.

She is also aware she is in the hospital for the hallucinations.

Current hospital medications:

Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Insulin Human 70/30 SUSP 7 Units (HUMULIN 70/30)
AC BREAKFAST

Insulin Human 70/30 SUSP 3 Units (HUMULIN 70/30)
AC DINNER

Insulin (Aspart) Correction Table (Novolog)
ACHS

Glucose CHEW 16 g (GLUCOSE)
Q15MINPRN

Dextrose SOLN 12.5-25 g (DEXTROSE)

Related Notes

Q15MINPRN

Glucagon SOLR 1 mg (GLUCAGEN)
Q15MINPRN

Ciprofloxacin 400 mg (CIPRO)
NOW THEN Q24HR

Furosemide TABS 40 mg (LASIX)
DAILY

Carvedilol TABS 25 mg (COREG)
BID

Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Past medical history: CHF, CAD, DM, ischemic cardiomyopathy

Past surgical hx: none

Family hx: non- contributory

Allergies: as noted in chart, epic

Social history: lives in her house for many years - now with her husband
and her oldest son, Nick. She has a chair lift in her house but does not
use and just stays in her bedroom. Denies alcohol or tobacco

Review of systems: All systems were discussed with the patient,
including cardiac and respiratory, and were negative and as per HPI.

Vitals: BP 133/59 | Pulse 69 | Temp 98.1 F (36.7 C) | Resp 16 | Ht 4' 8"
(1.422 m) | Wt 45.133 kg (99 lbs 8.0 oz)

Mental status:

1) Alert and orient x3, aware of past presidents in order until reagan.

She was able to name 14 animals in one minute. She is aware of what
happened on 9/11 and recalls the tsunami and Katrina. She did not recall
the name of the hurricane but knew it was a hurricane.

She was able to repeat 3 object and recalls 1/3 agler distraction. She
was able to trails b until 10 J. She was able to do serial 7's and spell
world forwards and backwards. She could follow complex commands. She can
not see very well and was not given a clock to draw or reading materials.

She was able to give history of her childhood and this was confirmed
with her husband who admits the hx is correct.

She was slightly tangential but she was able to relocate.

General: dishelved appearance and uncombed hair. Slight smell to her as
well. language and speech intact

Chest: clear to auscultation and percussion

Heart: regular rate and rhythm with normal S1 and S2

Related Notes

Neurologic:

CRANIAL NERVES:

Cranial Nerve II: Visual Fields can not be tested d/t bil cataracts and can only see shadows and light. Pupils equal round and reactive to light.

Cranial Nerves III, IV, VI: EOM full without dysconjugate gaze- able to follow light and commands to look right, left, up down, No nystagmus. No Ptosis

Cranial Nerve V: Mastication intact. Facial Sensation normal

Cranial Nerve VII: Face is symmetrical

Cranial Nerve VIII: Hearing grossly intact bilaterally to finger rub

Cranial Nerve IX, X: Palate elevation midline

Cranial Nerve XI: Sternocleidomastoid and Trapezius Muscles are symmetrical and normal in power

Cranial Nerve XII: Tongue protrudes midline without atrophy or fasciculations

MOTOR EXAM:

Good power in all four extremities with atrophy in bil distal extremities and lower extremities. No fasciculations. Tone is normal.

No tremor at rest, posture, or intention. No cogwheeling or rigidity.

REFLEXES:

Symmetrical hypoactive reflexes in the upper and lower extremities. No achilles reflexes bilaterally, no biceps reflex on right

Babinski Flexor response bilaterally

SENSATION:

Intact sensation to pin, and decreased vibration withdraws to painful stimuli

COORDINATION:

difficult to test as patient can not see instructions. She had difficulty finding her nose bilaterally. No obvious ataxia, Slight postural tremor bilaterally

GAIT and STANCE:

did not test as patient has not been walking in several months after a injury

Laboratories/ Imaging:

I reviewed pertinent labs in epic and CTOH in pacs personally

Impression/ recommendations:

1) Hallucinations - ongoing for at least the last 6 months to 1 year per family and business partner. Not contributing to harm to herself or others. If sleep affected by it, could consider a mild sedative for sleep such as temezapam or seroquel 12.5 mg. No other neurological signs to suggest dementia or parkinsonism(Lewy body disease) or stroke. She did fairly well on testing and perhaps got her at a good time. Her memory should probably be followed as an outpatient.

Per family she has been having hallucinations for some time now and they just wanted to get her checked out. UTI was found and could contribute to her fluctuation. Agree with UTI treatment.

2) Please call with concerns

3) Paged Dr. Unger to discuss above, will await call back.

Smita Patel, D.O.

Department of Neurology

Related Notes
Pager 2740

<u>Author</u>	<u>Service</u>	<u>Author Type</u>	<u>Filed</u>
Smita Patel	(none)	Physician	03/16/2007 1107

Procedure

1. NEUROLOGY CONSULT (IP) [83958776] ordered by ALJ, AMAN at 09/14/07 2045

Neurology Attending Note

September 16, 2007

Patient seen this AM and again was seen to be talking to herself this Am. the conversation seemed appropriate in that she was talking about how she can not really see well due to her cataracts. She would not call herself blind because she can still see light. When i interrupted her talking, she did recall who I was based on voice. She states she recalls the 3 objects i asked her to remember yesterday spontaneously and was able to state all 3 correctly.

She has no complaints this AM and feels that she could go home. If she does not go home, she would be giving her husband and son a break and some rest,

All systems were discussed with the patient, including cardiac and respiratory, and were negative and as per HPI.

Current hospital medications:

Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Insulin Human 70/30 SUSP 7 Units (HUMULIN 70/30)
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Furosemide TABS 40 mg (LASIX)
DAILY

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Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Vs: BP 137/56 | Pulse 72 | Temp 98.3 F (36.8 C) | Resp 20 | Ht 4' 8"
(1.422 m) | Wt 97 lbs 12.8 oz (44.362 kg)
Neuro exam unchanged from yesterday, and MS appears intact. No signs of
fluctuation based on 2 visits with her and with medical student
observations as well.

Labs: reviewed in EPIC

Impression/ recommendations:

Hallucinations - ongoing for at least the last 6 months to 1 year per
family and business partner. Not contributing to harm to herself or
others. If sleep affected by it, could consider a mild sedative for sleep
such as temezapam or seroquel 12.5 mg. No other neurological signs to
suggest dementia or parkinsonism (Lewy body disease) or stroke. She did
fairly well on testing. No signs of MS fluctuations. Her memory should
probably be followed as an outpatient.

Per family she has been having hallucinations for some time now and they
just wanted to get her checked out. UTI was found and could contribute to
her fluctuation. Agree with UTI treatment please call with changes

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Procedure

Page 13 of 16

Smita Patel, D.O.
 Department of Neurology
 Pager 2740

<u>Author</u>	<u>Service</u>	<u>Author Type</u>	<u>Filed</u>
Michael Shane McGuire	(none)	Physician	09/17/2007 1430

CC: Berenice Ventrella (xxx-xx-7386), is a 88YO female referred by SUSAN SHAPIRO, MD for a consultation regarding retention.

HPI: Symptoms: incomplete emptying
 Location: bladder
 Duration: unknown
 Associated findings: pyuria and confusion
 Modifying factors: pvr 350cc

Past Medical History

ACCIDENTAL FALL FROM BED
 2/2/03

SHORTNESS OF BREATH
 2000

UNSPECIFIED CHRONIC ISCHEMIC HEART DISEASE
 1999

DIABETES MELLITUS
 1990

ACUTE MYOCARDIAL INFARCT(aka MYOCARDIAL)
 4/17/2003

CONGESTIVE HEART FAILURE
 4/17/2003

BACKACHE NOS(aka BACK PAIN)
 5/15/2003

Author Service Author Type Filed

No past surgical history on file.

Meds:

Current hospital medications:

Insulin Human 70/30 SUSP 8 Units (HUMULIN 70/30)
AC BREAKFAST

Insulin Human 70/30 SUSP 4 Units (HUMULIN 70/30)
AC DINNER

Quetiapine TABS 12.5 mg (SEROQUEL)
QHS

Ciprofloxacin TABS 500 mg (CIPRO)
NOW THEN Q24HR

Insulin (Aspart) Correction Table (Novolog)
ACHS

Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Glucose CHEW 16 g (GLUCOSE)
Q15MINPRN

Dextrose SOLN 12.5-25 g (DEXTROSE)
Q15MINPRN

Glucagon SOLR 1 mg (GLUCAGEN)
Q15MINPRN

Furosemide TABS 40 mg (LASIX)
DAILY

Carvedilol TABS 25 mg (COREG)
BID

Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Allergies:

Review of patient's allergies indicates no known allergies.

Social history:

Tobacco Use:

Never

Alcohol Use:

No

Family History

No family history on file.

REVIEW OF SYSTEMS:

Constitutional: - Fevers, - weight loss

eyes: - blindness, - diplopia

Physical exam:

Blood pressure 172/62, pulse 72, temperature 97.8 F (36.6 C), resp. rate 18, height 4' 8" (1.422 m), weight 45.450 kg (100 lbs 3.2 oz).

Gen Appearance NI

Mood hallucinating

Skin NI

Neck NI

Resp Effort NI

Peripheral Vasc NI

Lymphatic NI

Bldr/Kid NI

Hernia Absent

Liver/Spleen NI

Stool Not Indicated

CBC:

WBC 7.2 09/14/2007

RBC 4.30 09/14/2007

HGB 12.4 09/14/2007

HCT 36.3 09/14/2007

PLT 203 09/14/2007

BMG:

Author	Service	Author Type	Filed
GLU	152	09/17/2007	
NA	143	09/17/2007	
K	3.6	09/17/2007	
CL	110	09/17/2007	
CO2	27	09/17/2007	
BUN	31	09/17/2007	
CREAT	1.0	09/17/2007	
CA	8.7	09/17/2007	

Urinalysis:

UACOL YELLOW 09/14/2007
UAPP CLEAR 09/14/2007
USPG 1.015 09/14/2007
PHU 6.0 09/14/2007
UAPROT NEGATIVE 09/14/2007
GLUUR NEGATIVE 09/14/2007
UAKET NEGATIVE 09/14/2007
BILI NEGATIVE 09/14/2007
URBLD 1+ 09/14/2007
NITRITE NEGATIVE 09/14/2007
UROBIL 0.2 09/14/2007
LEUKEST 3+ 09/14/2007
MUCTHRU NONE SEEN 09/14/2007
SQEPIUR RARE 09/14/2007
BACTU 1+ 09/14/2007
WBCURINE TNTC 09/14/2007
URBC 0-4 09/14/2007

ucx mixed flora
pvr 350cc

Impression: pyuria/ confusion/elevated pvr in elderly pt. Agree w/
treatment even though cx no specific organism. Would also check ct abd-
stone protocol given pyuria. Would give decath trial in am post
beginning treatment to evaluate incomplete emptying.

Plan: will follow

END OF REPORT
